APPEAL NO. 93407

On April 29, 1993, a contested case hearing was held in (city), Texas, with hearing officer) presiding. The hearing officer determined that the claimant, who is the respondent, had not reached maximum medical improvement (MMI). The hearing officer adopted the opinion of the designated doctor, and found that the great weight of other medical evidence was not to the contrary.

The carrier has appealed, arguing that the great weight and preponderance of the evidence is against the decision of the hearing officer. The carrier recaps the medical evidence which it argues greatly weighs against the report of the designated doctor, and points out evidence wherein claimant admitted to having exaggerated his claim. The claimant's response, significantly, does not argue that such admissions were untrue. Rather, he points out that the admissions were recorded by a psychologist, and cannot, therefore, be considered as part of the "great weight of medical evidence" against the report of the designated doctor. The claimant also argues that if the psychologists records were not reviewed by the designated doctor, the carrier bears some responsibility for failure to provide such records. The claimant asks that the hearing decision be upheld.

DECISION

We reverse the decision of the hearing officer, and remand the case for re-evaluation by the designated doctor, which should include his evaluation of reports of the Pate Institute, as well as all pertinent facts. We agree that the report of the designated doctor is against the great weight of other medical evidence, but are unable to adopt the opinion of the treating doctor as there is no evidence it was based upon his personal examination or conducted in accordance with the AMA Guides to the Evaluation of Permanent Impairment.

The claimant, an order puller, stated that he was injured on September 26, 1991, as he pulled on an order of peaches, fell backward, and hit his head on a steel shelf. He was employed by Affiliated Foods, Inc.

Claimant testified that he went to the emergency room two days later. Dr. Jeffrey Cone, a neurosurgeon, became his treating doctor and remained so until August 1992, when he released claimant to work and completed a TWCC-69 Report of Medical Evaluation, finding that claimant reached MMI with a 0% impairment. Claimant said that he was examined by a nurse-practitioner in August, and admitted that he told this office he had not had seizures recently. Claimant stated he sought reemployment from his employer in September, but was not rehired.

Claimant acknowledged that he had been treated by the Pate Institute, by agreement with the carrier. He stated he saw Dr. M, twice, once in March 1992, and again in July 1992. He denied that he told Dr. MDowell that he had essentially exaggerated the claim, or that he had only had one seizure. In cross-examination, he admitted that he told her in July that he was ready to return to work and had no blackouts since his March 1992 visit.

He stated that seizures and blackouts seemed different to him. Claimant said he did not know why Dr. Mwould put things in her report that he had not told her. At one point on direct examination, he testified that the night before the July examination by Dr. M, he had only 4-5 hours sleep, which was low for him, and that less sleep may have made a difference in how he answered "the question." The question that he may have answered differently was not clearly identified in the record.

Claimant stated that in January 1993, he was taken to the emergency room of the hospital, where his girlfriend gave a description of what happened to him because he didn't know. He stated that he had two or three seizures in the previous day.

Claimant attributed blackouts, seizures, blurry vision, dizziness, memory loss, and weakness to his injury. He stated that his appointment with the designated doctor, Dr. E, lasted three and a half hours. Claimant said that after his accident, he did not lay on the floor for about 45 minutes and never told anyone that he did.

Summary of Medical Evidence in record

Oct. 1-4, 1991Dr. JC, reporting 10/28/91 on claimant's hospitalization at Northwest Texas Hospital from October 1, 1991 through October 4, 1991. CT scan reveals only a cyst in the sinus. Dr. C opines that due to diffuse symptoms he described, likely diagnosis is post-concussion syndrome. Advised to stay off work 2-3 weeks. If headaches persist, ENT consult advised to determine role of cyst.

Oct. 2, 1991Normal MRI of brain reported

Oct. 3, 1991Routine EEG/ no significant abnormality noted awake, drowsy EEG.

Oct. 22, 1991Dr. Cone/ first visit since hospitalization. Same diagnoses of sinusitis and post-concussion syndrome. ENT referral to Dr. S. MRI- cyst. "EEG-Nl."

Oct. 30, 1991Dr. S examines claimant, later reports normal ENT examination, opines sinus cysts are not of any significance.

Nov. 14, 1991Dr. Cone referred claimant to Dr. Rn, noting that his examination remains normal, and he suspects an underlying conversion overlay.

Dec. 6, 1991Dr. LR, Report of neurological 2nd opinion. Recites history of accident, complaints of constant pain and ear ringing, numbness extending down side of body, and passing out, 12-20 times per day. Says no apparent change in appearance when he becomes unconscious.

Reports trouble with memory since accident, head and neck pain. Cerebellar examination conducted by Dr. R performed erratically, although performance improves when distracted with conversation. Wild swaying when standing observed, but patient does not fall. Impression - "closed head injury with no evident objective neurological dysfunction on testing today. The patient may have some mild cognitive losses, however his interview today yields many inconsistencies of cognition which are not at all typical for a post concussion cognitive impairment. His personality style and approach exhibit marked hysterical features and these factors are also supported by his contradictory findings of nonphysiological impairments on his objective neurological examination." Dr. R recommends a repeat EEG and, if negative, referral to a Dr. H to determine the contribution of psychological overlay.

Dec. 19, 1991 Normal, adult, awake EEG/ Northwest Texas Hospital

March 3, 1992 Dr. C/ notes history that claimant is better now but has blackout spells and dizziness. "No abnormality on exam . . . No atrophy." Referral made to psychiatrist, Dr. S.

March 4, 1992 Pain evaluation of right forearm and hand, to evaluate injury from fall. X-ray report indicates no acute or chronic bone or joint abnormality in right forearm or hand. Similar report rendered with regard to right ribs, showing "no recent or remote fracture."

March 18, 1992 Evaluation by Pate Rehabilitation Endeavors, Inc. - signed by T., Psychological Associate; JM Licensed Psychologist; and ME, Diplomate in Clinical Neuropsychology. Recites, in history of accident, that claimant passed out for 30-45 minutes following blow to head. Recites history of being hit on head a month prior to accident at work. Reports that three weeks prior to this exam, claimant said he blacked out and broke some bones in hand and cracked some ribs. Notes that when asked to describe symptoms, claimant "spontaneously reported blurred vision, headaches, dizziness, black-outs, and a loss of strength on the right side." Questioned more specifically, he also reported ringing in ears, memory and comprehension problems, sleep difficulties, decreased coordination and decreased patience. Results of Formal Personality Assessment are noted as response in an exaggerated manner, "endorsing a wide variety of inconsistent symptoms and attitudes." The letter notes that the resulting profile was not a valid indication of personality and

symptoms. A pattern of acquired loss of cognitive efficiency was noted. Recommendation is made that basilar skull fracture and vestibular dysfunction be ruled out.

March 26, 1992 Letter from Dr. C to EW, adjuster for carrier. States that he is unable to account for continued, diffuse symptoms that claimant continues to have. "The most likely diagnosis is post-concussion syndrome, though this is primarily a diagnosis made by exclusion or based upon a previous history of closed head injury." Dr. Cone goes on to say there is very little else he can do, encourages further thorough examination to rule out "post traumatic seizure disorder, though this would be highly unlikely."

July 29, 1992 Neurological Re-evaluation report. Report by P, signed by JM, and MEH notes claimant indicates he is ready to return to work. A significant portion of the text of this report relating to claimant's apparent self-evaluation of the merits of his claim is cited below. The report documents both decline and improvement over previous testing. "The pattern which emerges . . . is highly suggestive of frontal lobe dysfunction which includes the difficulty with sustained attention, impaired visual scanning, and motor programming deficits." Notes that problems with interpersonal relationships, coping, and problem solving appear to be longstanding and not related to accident.

August 25, 1992 Date MMI found by Dr. C to have been reached by claimant, with 0% impairment. Narrative reports that this was date claimant last seen in office, that he reported "no blackouts" and was ready to return to work. Records that EEG taken 12-9-91 was normal. Specific and subsequent medical report filed for August 25th visit notes that claimant reported no blackouts since "March or May." Claimant reports that he was nearly normal. Released to return to work.

The claimant's testimony, as well as the answers given by Dr. C in his deposition on written questions, indicate that the examination on August 25 was conducted by a nurse-practitioner, acting under the supervision of Dr. C.

One of the carrier's major arguments is based on evidence set forth in the P report signed by Dr. M and Dr. H on July 29, 1992. This evidence was submitted by claimant, and no objection was lodged to the expertise of the Pate Institute evaluators. Pertinent portions of that report are as follows:

Lengthy discussions of the circumstances leading up and following Mr. P's on the job

> injury resulted in very clear and seemingly honest self-evaluation on Mr. P's part. In retrospect, Mr. P states his belief that he suffered "an accident," not an "injury" on his job. Furthermore, he admitted that tests administered by the hospital (following the accident) were experienced as frightening to him. Specifically, he stated that he became fearful that "they would find something really wrong" and consequently he created symptoms "bigger" than he feared physicians might find in order to "hide behind them." While Mr. P indicates that he did experience one episode, the weekend immediately following his injury, in which he got up from bed during the night and fell. He also now clarifies that he was taking several medications at the time and likely got up too quickly, became dizzy, and fell. Apparently, Mr. P then presented "blackouts" and related symptoms as relatively frequent occurrences. As Mr. P states he initially created "something to hide behind and then it became bigger than [himself]" (i.e. blackouts). Further evaluation and discussion with Mr. Papa confirms that multiple previously reported symptoms were more reflective of pre-existing anxiety and multiple life stressors than his on the job "accident."
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> At a later point in the report, these impressions are noted:
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> Psychologically, Mr. P's primary present distress is his recognition and acknowledgement that he single-handedly turned an "accident" on his job into an "injury" to which he inappropriately attributed multiple pre-existing physical and emotional problems . . . . Mr. P does not want any family members to know about his magnification and maintenance of symptoms . . . .

On October 13, 1992, the Texas Workers' Compensation Commission (Commission) appointed "Dallas Rehabilitation Institute" as the designated doctor. The claimant's attorney then wrote the clinic inquiring about which doctor would be primarily responsible for the examination. This letter stated that the attorney was sending all medical reports that he had in his possession, although those reports were not specified. The letter further stated that the carrier "may" supply you with additional records. A copy of the letter was sent to the adjuster for the carrier.

The claimant was examined by Dr. E of the Dallas Rehabilitation Institute on November 30, 1992, who completed a TWCC-64 subsequent medical report, a TWCC-69, and a narrative entitled "Report of Independent Medical Evaluation." On the TWCC-69, Dr. E stated that claimant had not reached MMI, and the anticipated date for MMI would be "9-26-93." However, on the TWCC-64, Dr. E indicated that MMI would be "post completion of above refs." The TWCC-64 and narrative recommended two-week inpatient evaluation and neurological evaluation for seizures. Dr. E describes the initial accident as causing loss of consciousness for at least 45 minutes. Dr. E also indicates his understanding that

claimant's history is that he has had blackout spells "versus seizure activity" since his accident. Dr. E's report indicates awareness, or review, of records of Dr. C, Dr. R, and medical tests done at the hospital. His sole reference to Pate Institute is "[h]e (apparent reference to Dr. C) also concurred with recommendation for neuropsychological evaluation, which was apparently then done subsequently at Pate rehab." Dr. E's references in his recommendations to seizures are cast in language "if he truly is having seizures this frequently . . . ." The claimant testified that his evaluation by Dr. E lasted about 3-1/2 hours.

On January 10, 1993, claimant went to the emergency room at Northwest Texas Hospital, stating that his girlfriend told him he had been having seizures. A narrative by Dr. N, accompanies the report. This report indicates that claimant is to have an evaluation the following month. The report indicates that claimant reported having seizures 2-3 times a week since the head injury. The doctor stated that claimant's left pupil was slightly smaller than the right (characterized as minor anisocoria), and he had left sided grip weakness, but that both conditions gradually resolved while he was in the emergency department. Although claimant's attorney argued at the hearing that this hospital visit was probative of the occurrence of a seizure, no such observation by hospital personnel is recorded in the records, and there is no evidence in the record to support his contention that the eye condition and weakness indicate that a seizure was occurring. The claimant was prescribed Dilantin as a result of this visit. Claimant indicated that Dilantin was unsuccessful in resolving his seizures.

On May 8, 1992, HC, ophthalmologist, noted that claimant reported blurry vision since his September 1991 accident. The doctor had no opinion one way or the other on the existence of a concussion injury to the brain. He did note no injury to the eye, stated that claimant was nearsighted but had no glasses, and said correction of his vision with glasses improved claimant's vision significantly. An earlier medical report completed by Dr. Currie indicates that claimant related to him a history of hitting his head and then falling forward on his face.

Depositions on written questions were taken of Dr. R and Dr. C. Dr. R is a neurologist and Dr. C a neurological surgeon. Dr. R stated that the results of her cranial nerve examination revealed no objective dysfunction, but she did note behavioral features suggestive of a hysterical personality style, which she described as consistent with a person who "will tend to show changes in physical functioning, predominantly subjective, as a means of expressing the anxiety or other psychological coping difficulties which they have." She also noted inconsistencies in claimant's exhibition of patterns of right-sided weakness. "This means that the formal examination where the patient knew he was being tested revealed evidence of the patient attempting to show weakness which was not apparent when the patient was functioning in a routine setting under observation, but during which time he was unaware that his muscle function was being noted." As to a sensory examination she conducted, she noted discrepancies in his subjective reports of sensations

and objective findings on the formal portion of the sensory examination. Dr. C stated that his use of the term "underlying conversion overlay" would refer to the possibility of symptoms "perhaps exaggerated on an emotional or physical level." Dr. C indicated that his office nurse-practitioner, under his direction, examined claimant August 25, 1992, which examination was normal. Dr. C does not answer the question posed about whether an examination was conducted in accordance with the AMA Guides to the Evaluation of Permanent Impairment (Guides) with a direct yes or no and it is frankly unclear to determine from the answers given if the Guides were used. Both Dr. R and Dr. C, asked to assume aspects of what claimant reported to Dr. M in July, stated that such statements would be consistent with their opinions relating to the subjectivity of claimant's complaints and hysterical personality style. They both indicated that their opinions would not change even if a seizure were documented in January 1993.

In summary, the records in the case indicate nearly a total absence of objective evidence of injury. Even if "injury" were demonstrated, the records in the case indicate that claimant's condition has been basically unchanged, except for vision correction to his nearsightedness brought about by glasses. The report of the designated doctor that claimant has not reached MMI appears to be contingent upon whether claimant is "truly having seizures."

We believe that when a designated doctor's report is premised upon facts and assumptions that are erroneous or inaccurate, some of the "other medical evidence" that may outweigh the designated doctor's report can be derived from the report itself. In this case, Dr. E appeared to take as given facts that claimant's own testimony at the hearing indicated were not accurate--that claimant had seizures ever since his accident. Claimant testified that he was truthful when he related no seizures or blackouts in the period from March to July or August 1992 to Dr. C and Dr. M. Further, we would agree with the carrier's contention that the designated doctor's report indicates that he did not have the Pate reports or did not review them. Those reports include, of course, the assertions by Dr. M that claimant essentially admitted to faking symptoms or history of his injury. Because the hearing officer regrettably chose to omit entirely any discussion of the evidence from his decision, and coupled it with bare minimal "fact" findings that essentially track statutory language from the designated doctor portions of the 1989 Act, we are unable to determine what the hearing officer made of this, as well as the numerous contradictions in the recited histories of the course of claimant's injury.

We cannot, as claimant's attorney suggests, simply turn a blind eye to Dr. M's report because it is not rendered by a doctor or because it may be the carrier's fault if such records were not given to Dr. E. The commission must be concerned with the integrity of the process and the accuracy of its appointed designated doctor's conclusions, especially when, as in this case, prior evaluations are critical to an accurate assessment of the claimant's condition by that doctor. Frankly, the Commission field office should have taken the lead

in ensuring that all records were supplied to the designated doctor. To suggest that a result akin to a discovery sanction (failure to produce the record will preclude its use by the designated doctor) should apply here is a contention we must reject.

We also reject claimant's contention that "medical evidence" is limited to the opinions of a doctor. Clearly, Article 8308-1.03(20) includes within the ambit of medical care those health care services rendered by persons who are not physicians. While a trier of fact might weigh evidence provided by health care providers in accordance with their respective degrees and experience, we find nothing precluding the consideration of such reports from non-physician health care providers on matters relating to the injuries purportedly sustained, about which their expert opinion is sought by agreement, in tandem with doctor's reports. *See* Texas Workers' Compensation Commission Appeal No. 93383, decided June 30, 1993.

But leaving this aside, we do not believe that this commission is, or ever should be, constrained by Article 8038-4.25 or 4.26 to have tunnel vision when evidence comes forward that the condition on which the commission has been asked to determine MMI may not exist. Credibility need not be reported as an express issue in a case; it underpins the integrity of the hearings process. In this case, claimant did not have an alternative explanation for statements relating to exaggeration of his claims recorded in the Pate Institute July report--he flatly denied that he made them. (Except, perhaps, with respect to one answer to a question not identified in the record which may have been influenced by fewer hours of sleep). Because of this, the statements in issue cannot simply be dismissed as failure to communicate. The statements attributed to the claimant in the Pate Institute report are rich and detailed. They are true, or they are not. If false, they would seem to subject the declarant to sanction from her licensing authority. *See* TEX. REV. CIV. STAT. ANN. art. 4512c, § 23. The doctor would appear to have nothing to gain from recording such statements if not made, and the claimant indeed could not attribute a motive. This fact weighs heavily in favor of a finding that claimant made such statements to Dr. M. This need not mean that claimant was affirmatively untruthful; his sworn denial that he made such statements could be taken as consistent with his asserted memory loss, rather than not having made such statements. In any case, the Pate Institute's written evaluations are critical information which the designated doctor must consider, and which must be frontally addressed, not simply ignored, by a hearing officer. Because the designated doctor's report opines about what the Pate Institute "apparently" did, this tells us that Dr. E did not have the reports when he performed his evaluation.

We would tend to agree that the great weight of medical evidence in this case, including that found within the four corners of the designated doctor's report as premised upon erroneous or incomplete information, goes against that doctor's report. The problem presented here is that the impairment assessment of 0% in this case was apparently not done by Dr. C, or done with the use of the Guides. (These are matters that should be cleared up on the remand of this case). All in all, the best and fairest disposition of this

matter would be to return it to the designated doctor for consideration of the Pate Institute reports, and other pertinent medical information, including the differing information supplied by the claimant as to the frequency of claimant's seizures and blackouts.

A final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to Article 8308-6.41. *See* Texas Worker's Compensation Commission Appeal No. 92642, decided January 20, 1993.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Robert W. Potts
Appeals Judge

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Thomas A. Knapp
Appeals Judge